

Plan of Correction

Program Name: Minnehaha County Detox	Date Submitted: 12/18/19	Date Due: 1/18/20
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Administrative POC-1	
Rule #: ARSD 67:61:07:04	Rule Statement: <p>Closure and storage of case records. The agency shall have written policies and procedures to ensure the closure and storage of case records at the completion or termination of a treatment program including:</p> <p style="margin-left: 40px;">(1) The identification of staff positions or titles responsible for the closure of case records within the agency and the MIS;</p> <p style="margin-left: 40px;">(2) Procedures for the closure of inactive client records, that are clients who have not received services from an inpatient or residential program in three days or clients who have not received services from an outpatient program in 30 days; and</p> <p style="margin-left: 40px;">(3) Procedures for the safe storage of client case records for at least six years from closure.</p>
Area of Noncompliance: The agency had a policy regarding closure of records however the policy stated the record would be closed after six months of the client not receiving services. The policy should be updated to three days after not receiving services.	
Corrective Action (policy/procedure, training, environmental changes, etc): Detox Client Record Management Systems will be updated to include that client records will be closed after 3 days of not receiving services rather than 6 months.	Anticipated Date Achieved/Implemented: Date 1/15/2020
Supporting Evidence: A copy of the updated policy will be included along with this corrective action plan.	Person Responsible: Westcare/Detox Program Director
How Maintained: Staff will be notified of the updated policy and a copy of the policy will replace the old copy in the staff policy and procedure manual(s)	Board Notified: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/>

Client Chart POC-1	
Rule #: ARSD 67:61:07:10	Rule Statement: <p>Progress notes. All programs, except prevention programs, shall record and maintain a minimum of one progress note weekly, when services are provided. Progress notes are included in the client's file and substantiate all services provided. Individual progress notes must document counseling sessions with the client, summarize significant events occurring, and reflect goals and problems relevant during the session and any progress in achieving those goals and addressing the problems. Progress notes must include attention to any co-occurring disorder as they relate to the client's substance use disorder.</p> <p style="margin-left: 40px;">A progress note must be included in the file for each billable service provided. Progress notes must include the following for the services to be billed:</p>

	<p>(1) Information identifying the client receiving the services, including the client's name and unique identification number;</p> <p>(2) The date, location, time met, units of service of the counseling session, and the duration of the session;</p> <p>(3) The service activity code or title describing the service code or both;</p> <p>(4) A brief assessment of the client's functioning;</p> <p>(5) A description of what occurred during the session, including the specific action taken or plan developed to address unresolved issues for the purpose of achieving identified treatment goals or objectives;</p> <p>(6) A brief description of what the client and provider plan to work on during the next session, including work that may occur between sessions, if applicable; and</p> <p>(7) The signature and credentials of the staff providing the service.</p>
<p>Area of Noncompliance: The progress notes reviewed had the same wording of what the client and provider plan to work on during the next session throughout the entire treatment episode. Each progress note should be individualized.</p>	
<p>Corrective Action (policy/procedure, training, environmental changes, etc): Detox Counselors will continue to meet with all patients on a weekly basis. The counselor will then document the session with a summary of what was discussed along with any and all plans and goals for the next session.</p>	<p>Anticipated Date Achieved/Implemented:</p> <p>Date 1/15/2020</p>
<p>Supporting Evidence: Detox counselors will document each individual encounter along with the plans and goals in the "Counselor's Progress Note" tab of the patient's electronic medical record.</p>	<p>Person Responsible: Detox Counselors</p>
<p>How Maintained: Detox Program Director with monitor documentations of individual sessions during quality care reviews/counselor supervisions</p>	<p>Board Notified: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> n/a <input type="checkbox"/></p>

Please email or send Plan of Correction to:

Accreditation Program
Department of Social Services
Division of Behavioral Health
3900 West Technology Circle, Suite 1
Sioux Falls, SD 57106

Email Address: DSSBHAcred@state.sd.us

WestCare Foundation, Inc.	WestCare South Dakota, Inc.
Policy Title: Client Record Management System	
Pages: 1 – 6	
Applicable Standards: CARF –Info. Mgmt. & Performance Improvement, and Records of Persons Served, South Dakota Administrative Rules 46:05:09:03, 46:05:09:04, 46:05:09:05, 46:05:09:06	
Approval: <i>Richard J. Steinberg</i>	
Date of Signature: 1-9-20	
Original Effective Date: 3/28/14 Revised Date: 1/9/20	

Client Record Management System

PURPOSE:

To establish a client record management system to ensure that client records are established, maintained in a secure, appropriate, and confidential manner and that all federal and state rules and regulations, including 42 Code of Federal Regulations, Part 2 and South Dakota Administrative Rules regarding client records are met.

POLICY:

It is the policy of WestCare that client records shall be kept secure from unauthorized access and maintained in accordance with all federal and state rules and regulations and all personnel adhere to agency record management procedures regarding content, organization, and use of records.

RESPONSIBILITY:

The Senior Vice President, Vice President, Area Director or designee, is responsible for the development, implementation and maintenance of policies and procedures governing client records.

The Directors are responsible for training staff regarding all policies and procedures governing client records and ensuring the security of client records. The Director is responsible for ensuring that that records are maintained in an up-to-date status with timely clinical documentation entries, and auditing the client record for a person discharged from the agency and ensuring that all deficiencies corrected by the respective staff prior to transferring the record for permanent storage.

Staff is responsible for entering data in the client record in a timely and accurate manner in accordance with established policies and procedures of WestCare and as required by applicable regulations, rules, and laws. The staff is responsible for maintaining up-to-date status with timely clinical documentation entries, and correcting all deficiencies prior to submitting the client record to the Director for permanent storage.

PROCEDURE:

There shall be a case record for each client. The case record describes the services provided and the client's progress in the program. The case record for residential programs shall include the

client's physical and mental health status at the time of admission. The client record shall provide information for the review and evaluation of the treatment provided to the client.

CONTENT -

Each client record shall contain the information required in client records by South Dakota regulations. All documents and document up-dates required by South Dakota Administrative Rules shall be completed within the time frames set forth in South Dakota Administrative Rules. [Timeframes specifically outlined in program policies pertaining to Assessment, Treatment Planning, Progress Notes, Discharge, etc.]

The client record contents shall meet all requirements of licensing and applicable accrediting agencies. This will include include:

1. The client record contents shall meet all requirements of licensing and applicable accrediting agencies.
2. Sufficient information to identify the client, to support the clinical impression and/or diagnosis(es), to justify the treatment and to document the results accurately.
3. All original entries into the client record shall be legible, accurate, concise, factual, and signed in black ink. Signatures on all records shall be original.
4. Each entry shall clearly show date, month and year and identity of the person making the entry.
5. Professional designation and status of the person writing in the record must be clearly shown.
6. Amendments or marked-through changes are initialed and dated by the individual making such changes adhering to the following guidelines:
 - a. An incorrect word, phrase, or sentence shall have a single line drawn through the incorrect word or words and the person doing so should initial and date above the lined out area and enter the correct word(s).
 - b. When the incorrect entry is more than one sentence place an "X" through the entire entry and write "ERROR" above the entry and initial and date the entry. The correct entry should be entered and make reference to the "ERROR" section.
 - c. No correction shall be made by writing over a word, letter or number.
 - d. No correction shall be made by using whiteout or erasure of a word, letter or number.
7. No documentation within records shall be deleted.

8. If records are maintained electronically, a staff member identifier code will be accepted in lieu of a signature.
9. All entries in the client record, which are abbreviated, shall be consistent with widely known and understood abbreviations.
10. Progress notes will be completed in accordance with the content and frequency requirements of South Dakota Administrative Rules for all clients of the organization.
11. While timely entries are expected, if the need arises to make an entry notation after documentation, the staff shall note: "Late Entry for (insert date with day, month and year), then document the event.

PROGRAM SPECIFIC CONTENT – Required by South Dakota Administrative Rules

1. STARS report forms, as directed by the division director;
2. Identification data;
3. Reports from referring sources;
4. Results of the client's initial assessment and planning, as required in § 46:05:09:07 or the client's standardized treatment needs assessment, as required in § 46:05:09:08;
5. The date of the client's orientation, as required in § 46:05:09:02;
6. Updated treatment plans, as required in § 46:05:09:09 and continued service criteria as required for the specific level of care being provided;
7. Progress notes, as required in § 46:05:09:10;
8. If appropriate:
 - a. Family evaluation, as part of the client's initial assessment or standardized treatment needs assessment;
 - b. Relevant correspondence;
 - c. Signed forms consenting to the release of information;
 - d. Referrals for service to other providers, including the reasons for referral
9. For transferred or closed cases, a transfer or discharge summary, as required in § 46:05:09:12.

Additionally required content per WestCare and accreditation standards:

- a) Name and address of the client and referral source
- b) Name and address of the client's emergency contact person
- c) Documentation of client orientation
- d) Physical health screening
- e) Biopsychosocial assessment
- f) Treatment Plans Reviews

ORGANIZATION

The client record of all WestCare treatment programs will include pertinent information on the client and be organized within the following sections of the record:

- Section 1 - Assessment
- Section 2 - Admission
- Section 3 - Legal
- Section 4 - Treatment or Intervention Plans
- Section 5 - Summary or Progress Notes
- Section 6 - Medical Information
- Section 7 - Miscellaneous

The data included in each section of the client record shall be determined by the respective Director and approved by the Vice President. This record format shall be available to all staff.

Closure of Client Records:

The case records of inactive clients shall be closed in a timely manner. Inactive clients are those who have had no contact by phone or by person with the agency for a period of time determined by the client's level of care at the time of discharge.

All case records of inactive clients of agencies accredited as a Level III.2-D clinically-managed residential detoxification program or Level 0.5 early intervention program shall be closed within three (3) days of the last contact.

All case records of inactive clients of agencies accredited as a Level I outpatient services program, a Level II.1 intensive outpatient treatment program, or a Level II.5 day treatment program shall be closed within three (3) months of the last contact.

All case records of inactive clients of agencies accredited as a Level III.7 medically-monitored intensive inpatient treatment program for adolescents or adults, or Level III.1 clinically-managed low-intensity residential treatment program shall be closed within one (1) month of the last contact.

Re-opening of Client Records:

If an inactive client returns for treatment, the client's last record will be reopened to ensure continuity of care.

Organization of Records for Storage:

All record information described above is permanently filed in the order indicated when it is prepared for storage.

A **Discharge Summary** is entered in the Client Record within five (5) working days for all South Dakota programs following discharge of the client (Level III.7, Level II.1, Level I.0, Level II.5, or Level III.1)

SECURITY -

Client records shall be:

1. Secured, maintained, stored in a locked area with limited key access.

2. Keys to the locked area that contains client records will only be issued to full or part-time staff who document in the record, to administrative staff and to those who perform the agency internal quality management audits.
3. Directors will maintain a log of client record storage areas and persons with keys and access.
4. WestCare is the custodian and owner of the client record and may release information only in compliance with 42 CFR Part 2.
5. **Off-site:** Original client records are not to be removed from the premises without the approval of the Regional Vice President, Area Director, Program Director and/or Program Director. Staff shall safeguard client confidentiality in the special conditions of off-site services or under the circumstances which require the need for client records to be transported to another site. All documentation will be secured (e.g. in a locked container and also locked in a vehicle or filing cabinet, (password protected on a laptop). Security and confidentiality of the client chart will be maintained at all times. In the event of transporting a client chart offsite, a log of all client charts will be given to the Program Director and/or Area Director or Regional Vice President for approval.

The log shall consist of the following:

- a. The name of the person transporting the record
- b. Name of client chart and/or client chart number, date and time client charts are removed
- c. The date and time charts are expected to be returned
- d. Signature of authorized person approving the event
- e. Signature of person transporting the client chart offsite
- f. Column to indicate the date and time client charts are returned, the signature of the person returning them and the Program Director or designee accepting the returned client charts.

All records shall be returned to the original site or secured storage site as soon as possible.

RECORD RETENTION AND DISPOSITION

Active and inactive records will be maintained and stored in the office of the respective programs.

Record maintenance and storage shall be governed by:

- The client record is the property of WestCare and is a legal document and as such must be complete prior to permanent storage.
- **6 Year Retention:** A client's case record shall be maintained by WestCare for a period of 6 years from the date of termination of treatment or service.

- **Discontinuation of Services:** In the event WestCare discontinues service operations or are taken over by another service, records containing client identifying information may be turned over to the replacement service or any other service provided the client consents in writing. If no client consent is obtained, the records shall be sealed and turned over to the appropriate South Dakota department to be retained for 6 years and then destroyed.

Client Records shall be destroyed according to the following procedures:

- 1) The clinical records personnel shall destroy the client record at the end of six (6) years, per South Dakota Administrative Rules. This may occur by incineration or shredding of the record and in accordance with Title 42, Code of Federal Regulations, Part 2, and section 397.501 (7), F.S.
- 2) Records destroyed shall be logged into a destruction log that records client name, client unique assigned number, program name, admission date, discharge date and the method used to destroy the record, e.g., incineration or shredding.
- 3) At the time designated for the destruction of records, the person in charge of that process will ensure that the person destroying the records is available via telephone at all times in the event that a legal process is initiated against WestCare it will be possible to stop the destruction process immediately upon telephone notification.

RECORD REVIEW

Client records shall be reviewed on a regular basis for required content, uniformity of format and completeness of content. Procedures detailing this process are included in the Quality of Care Review policy.

CLIENT ACCESS TO RECORDS

Clients may access their personal records by submitting a written request to the Director. Copies may be made at the client's expense (10 cents per page).